Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL HERMANN HOSPITAL SYSTEM
3200 SOUTWEST FRWY SUITE 2200
HOUSTON TX 77027

Carrier's Austin Representative Box
Box Number 15

MFDR Date Received
FEBRUARY 1, 2005

Respondent Name
ACE AMERICAN INSURANCE CO

MFDR Tracking Number
M4-05-4067-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The employee/patient…was emergently admitted to Memorial Hermann Hospital for severe burns. As soon as was reasonably possible, the hospital contacted the employer who instructed the hospital to Gallagher Bassett, which it did. Subsequently, the hospital provided the medical records to Gallagher Bassett. Gallagher Bassett issued reimbursement to the hospital for DOS 02/04/04 in the amount of $77,748.20 and DOS 03/05/04 in the amount of $18,642.07 on the basis for the hospital's failure to preauthorize and maximum reimbursement was allowed." "MHHS contends that the charges were fair and reasonable and medically necessary. Both dates of services were emergency admits and preauthorization is not required under the TWCC rules."

Amount in Dispute: $207,089.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Ace American paid a total of $96,390.27 for the hospital services provided. This constitutes 'fair and reasonable' reimbursement for the services provided. No additional reimbursement is due."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
February 4, 2004 through March 4, 2004	Inpatient Services	$167,963.55	$0.00
March 5, 2004 through March 17, 2004	Inpatient Services	$39,126.43	$0.00
TOTAL		$207,089.98	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401(c)(5)(A), effective August 1, 1997, 22 *Texas Register* 6264, requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate.
3. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - N, 04418-Not appropriately documented.
   - 04663-No MAR.
   - O-Denial after reconsideration.
   - No additional allowance is being recommended as the allowance reflects fair and reasonable fees in the geographic area where services were rendered. A consistent methodology has been applied to determine fair and reasonable amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement.
   - According to Labor Code 413.011 and Texas Administrative Code Sections 133.304(l)(1), 133.305(E)(1)(F) and 148.21(H), it is the medical providers burden to establish that its charges are fair and reasonable. Documentation must be provided that discusses, demonstrates and justifies that the payment amount being sought is fair and reasonable to ensure quality medical care and achieve effective medical cost control.

Findings

1. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 949.0 for dates of service February 4, 2004 through March 4, 2004; and 943.41 for dates of service March 5, 2004 through March 17, 2004. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
2. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor asks to be reimbursed the full amount of the billed charges in support of which the requestor states "MHHS contends that the charges were fair and reasonable and medically necessary. Both dates of services were emergency admits and preauthorization is not required under the TWCC rules."
   - The requestor did not discuss or explain how it determined that full reimbursement of the amount billed would yield a fair and reasonable reimbursement.
   - The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that "Alternative methods of reimbursement were considered… and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges…" 22 *Texas Register* 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.

- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	Date
Signature	Health Care Management, Executive Deputy Comm.	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

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